ZOLEDRONIC ACID Referral Order Form

FAX (877) 637-6691

VASCO INFUSION

WWW.VASCOINFUSION.COM
PH: 602-346-0204 FAX: 877-637-6691

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)*

Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ SS#: _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

ZOLEDRONIC ACID MEDICATION ORDERS

Dosing: ☐ **5** mg IV every _____ year (s)

Premeds: ☐ acetaminophen 500mg

Patient is currently taking Calcium/Vitamin D Supplement ☐ Yes ☐ No

Refills: _____

INDICATION/DIAGNOSIS

☐ Postmenopausal Osteoporosis
☐ Osteoporosis
☐ Glucocortoid- induced Osteoporosis
☐ Paget's Disease
☐ Other *(please specify in notes)*

***ICD-10** _____ **required**

NOTES (ADDITIONAL INFO)

_____ _____
Referring Physician's Signature Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ Creatinine (w/in 90 days) ☐ DEXA Results (w/in 2 years) ☐ Serum Calcium (w/in 90 days) ☐ Vitamin D (if available)

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY